Comments for the Record
House Committee on the Ways and Means
Hearing on Pathways to Universal Health Coverage
Wednesday, June 12, 2019, 10:00 a.m.
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Chairman Neal and Ranking Member Brady, thank you for the opportunity to submit these comments for the record to the Committee. These comments duplicate testimony the Budget Committee on this topic and include the need for a single-payer solution, three ways to provide universal coverage, funding issues and other considerations. Our tax reform proposals have also been modified. Attachments include repeated comments previously provided to the budget and revenue committees.

That there should be a single-payer program is obvious from the logic of social insurance. While there is an element of personal responsibility for some conditions, others are due to bad luck in the genetic lottery, also known as picking the wrong parents or bad Karma.

This is an issue with patients with mental illness and alcoholism (both of which, for this writer, came from an adrenal tumor that was not found until 45 years after symptoms presented – too late to arrest the resulting diseases), congenital heart disease and bad cholesterol, type I diabetes and most cancers.

There is not logic in rewarding people with good genes and punishing those who were not so lucky (which, I suspect, is most of us). Nor is there logic in giving health insurance companies a subsidy in finding the healthy and denying coverage for the sick, except the logic of the bottom line. Another term for this is piracy. Insurance companies, on their own, resist community rating and voters resist mandates – especially the young and the lucky. As recent reforms are inadequate (aside from the fact of higher deductibles and the exclusion of undocumented workers), some form of single-payer is inevitable. See attachment one for more on Surprise Medical Bills from yesterday's hearing in the Ways and Means Health Subcommittee.

There are three methods to get to single-payer, a public option, Medicare for All and single-payer with an option for cooperative employers.

The first to set up a **public option** and end protections for pre-existing conditions and mandates. The public option would then cover all families who are rejected for either pre-existing conditions or the inability to pay. In essence, this is an expansion of Medicaid to everyone with a pre-existing condition. As such, it would be funded through increased taxation, which will be addressed below. A variation is the expansion of the Uniformed Public Health Service to treat such individuals and their families.

The public option is inherently unstable over the long term. The profit motive will ultimately make the exclusion pool grow until private insurance would no longer be

justified, leading-again to Single Payer if the race to cut customers leads to no one left in private insurance who is actually sick. This eventually becomes Medicare for All, but with easier passage and sudden adoption as private health plans are either banned or become bankrupt. Single-payer would then be what occurs when

The second option is Medicare for All, which I described in an attachment to yesterday's testimony and previously in hearings held May 8, 2019 (Finance) and May 8, 2018 (Ways and Means). Medicare for All is essentially Medicaid for All without the smell of welfare and with providers reimbursed at Medicare levels, with the difference funded by tax revenue.

Medicare for All is a really good slogan, at least to mobilize the base. One would think it would attract the support of even the Tea Partiers who held up signs saying "Don't let the government touch my Medicare!" Alas, it has not. This has been a conversation on the left and it has not gotten beyond shouting slogans either. We need to decide what we want and whether it really is Medicare for All. If we want to go to any doctor we wish, pay nothing and have no premiums, then that is not Medicare.

There are essentially two Medicares, a high option and a low one. One option has Part A at no cost (funded by the Hospital Insurance Payroll Tax and part of Obamacare's high unearned income tax as well as the general fund), Medicare Part B, with a 20% copay and a $135 per month premium and Medicare Part D, which has both premiums and copays and is run through private providers. Parts A and B also are contracted out to insurance companies for case management. Much of this is now managed care, as is Medicare Advantage (Part C).

Medicaid lingers in the background and the foreground. It covers the disabled in their first two years (and probably while they are seeking disability and unable to work). It covers non-workers and the working poor (who are too poor for Obamacare) and it covers seniors and the disabled who are confined to a long-term care facility and who have run out their assets. It also has the long-term portion which should be federalized, but for the poor, it takes the form of an HMO, but with no premiums and zero copays.

Obamacare has premiums with income-based supports (one of those facts the Republicans hate) and copays. It may have a high option, like the Federal Employee Health Benefits Program (which also covers Congress) on which it is modeled, a standard option that puts you into an HMO. The HMO drug copays for Obamacare are higher than for Medicare Part C, but the office visit prices are exactly the same.

What does it mean, then, to want Medicare for All? If it means we want everyone who can afford it to get Medicare Advantage Coverage, we already have that. It is Obamacare. The reality is that Senator Sanders wants to reduce Medicare copays and premiums to Medicaid levels and then slowly reduce eligibility levels until everyone is covered. Of course, this will still likely give us HMO coverage for everyone except the very rich, unless he adds a high-option PPO or reimbursable plan.

Either Medicare for All or a real single payer would require a very large payroll tax (and would eliminate the HI tax) or an employer paid subtraction value added tax (so it would not appear on receipts nor would it be zero rated at the border, since there would be no

evading it), which we discuss below, because the Health Care Reform debate is ultimately a tax reform debate. Too much money is at stake for it to be otherwise, although we may do just as well to call Obamacare Medicare for All leave it alone.

The third option is an **exclusion for employers**, especially employee-owned and cooperative firms, who provide medical care directly to their employees without third party insurance, with the employer making HMO-like arrangements with local hospitals and medical practices for inpatient and specialist care.

Employer-based taxes, such as a subtraction VAT or payroll tax, will provide an incentive to avoid these taxes by providing such care. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid or Medicare for All. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. The employee-ownership must ultimately expand to most of the economy as an alternative to capitalism, which is also unstable as income concentration becomes obvious to all.

The key to any single-payer option is securing a funding stream. While payroll taxes are the standard suggestion, there are problems with progressivity if such taxes are capped and because profit remains untaxed, which requires the difference be subsidized through higher income taxes. For this reason, funding should come through some form of value-added tax. Our revised tax reform plan can be found in Attachment One.

The enactment of single-payer insurance raises the following concerns, most of which are addressed above. They are the funding of a public option, the funding of health care for veterans, which will replace Tri-Care and the funding of battlefield injuries, which may or may not be shifted to private care – but the latter must be medically indicated and done only with the consent of the veteran so served.

Timelines are also concerns. Medicare for All be done gradually by expanding the pool of beneficiaries, regardless of condition. Relying on a Public Option will first serve the poorest and the sickest, but with the expectation that private insurance will enlarge the pool of those not covered until the remainder can safely be incorporated into a single-payer system through legislation or bankruptcy.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment One – Tax Reform, May 22, 2019

For the past eight years, we have had a standard plan with four elements followed by explanatory paragraphs. The following is a different presentation with the same concepts. Future testimony will include this presentation as an appendix. Let us first define terms and acronyms.

Individual payroll taxes. These are optional taxes for Old Age and Survivors Insurance after age 60 (or 62). These will be collection of these taxes occurs if an income sensitive retirement income is deemed necessary for program acceptance. The ceiling should be lowered to reduce benefits paid to wealthier individuals and a floor should be established so that Earned Income Tax Credits are no longer needed. Subsidies for single workers should be abandoned in favor of radically higher minimum wages.

Income Surtaxes. Individual income taxes, which exclude business taxes, above an individual standard deduction of $50,000 per year. It will include initial cash distributions from inheritance (except those from the sale of estate assets, see below). This tax will fund net interest on the debt (which will no longer be rolled over into new borrowing), redemption of the Social Security Trust Fund, strategic, sea and non-continental U.S. military deployments, veterans' health benefits as the result of battlefield injuries, including mental health and addiction and eventual debt reduction.

Asset Value-Added Tax (A-VAT). A replacement for capital gains taxes and the estate tax. It will apply to assets held for a longer period of time, exercised options, inherited assets and the profits from short sales. Tax payments for option exercises and inherited assets will be reset, with prior tax payments for that asset eliminated so that the seller gets no benefit from them. In this perspective, it is the owner's increase in value that is taxed. Free assets to the seller will be counted as such. As with any sale of liquid or real assets, sales to a qualified broad-based Employee Stock Ownership Plan will be tax free. These taxes will fund the same spending items as income or S-VAT surtaxes. This tax will end Tax Gap issues owed by high income individuals.

Subtraction Value-Added Tax (S-VAT). These are employer paid Net Business Receipts Taxes that allow multiple rates for higher incomes, rather than collection of income surtaxes. They are also used as a vehicle for tax expenditures including healthcare (if a private coverage option is maintained), veterans' health care for non-battlefield injuries, educational costs borne by employers in lieu of taxes as either contributors, for employee children or for workers (including ESL and remedial skills) and an expanded child tax credit.

The last allows ending state administered subsidy programs and discourages abortions, and as such enactment must be scored as a must pass in voting rankings by pro-life organizations (and feminist organizations as well). An inflation adjustable credit should reflect the cost of raising a child through the completion of junior college or technical training. To assure child subsidies are distributed, S-VAT will not be border adjustable.

The S-VAT is also used for personal accounts in Social Security, provided that these accounts are insured through an insurance fund for all such accounts, that accounts go

toward employee-ownership rather than for a subsidy for the investment industry. Both employers and employees must consent to a shift to these accounts, which will occur if corporate democracy in existing ESOPs is given a thorough test. So far it has not.

Regardless, S-VAT funded retirement savings will be credited equally for every worker, which allows for funding both the current program and personal accounts and lessens the need for bend points in benefit calculations. It also has the advantage of drawing on both payroll and profit, making it less regressive.

Invoice Value-Added Tax (I-VAT) Border adjustable taxes will appear on purchase invoices. The rate varies according to what is being financed. If Medicare for All does not contain offsets for employers who fund their own medical personnel or for personal retirement accounts, both of which would otherwise be funded by an S-VAT, then they would be funded by the I-VAT to take advantage of border adjustability. I-VAT also forces everyone, from the working poor to the beneficiaries of inherited wealth, to pay taxes and share in the cost of government. Enactment of both the A-VAT and I-VAT ends the need for capital gains and inheritance taxes (apart from any initial payout). This tax would take care of the low income Tax Gap.

I-VAT will fund domestic discretionary spending, disability and survivors insurance (which will no longer be tied to income and shall be raised to the increased minimum wage rate and adjusted for inflation), and OASI employer contributions if personal accounts are not enacted and non-nuclear, non-deployed military spending, possibly on a regional basis. Regional I-VAT would both require a constitutional amendment to change the requirement that all excises be national and to discourage unnecessary spending, especially when allocated for electoral reasons rather than program needs.

As part of enactment, gross wages will be reduced to take into account the shift to S-VAT and I-VAT, however net income will be increased by the same percentage as the I-VAT. Adoption of S-VAT and I-VAT will replace pass-through and proprietary business and corporate income taxes.

Carbon Value-Added Tax (C-VAT). A Carbon tax with receipt visibility, which allows comparison shopping based on carbon content, even if it means a more expensive item with lower carbon is purchased. C-VAT would also replace fuel taxes. It will fund transportation costs, including mass transit, and research into alternative fuels (including fusion). This tax would not be border adjustable.

Attachment Two – Ways and Means Health Subcommittee, Protecting Patients from Surprise Medical Bills, May 21, 2019

Participants in Catastrophic Care with a Health Savings Account are never surprised by unexpected medical bills, since they signed up for it. If they do not realize that there will probably be a gap between the catastrophic deductible and the savings account, then it is on them. Adding a portable Medical Line of Credit would still create unexpected costs, but they would at least be funded at service – although this would limit the usefulness of the system in ending care when it is not needed. Most people will put access ahead of long-term savings. It is why the poor under-invest in tax favored savings accounts.

Beneficiaries of comprehensive health care are surprised when they see bills that will eventually be covered by their carrier, as well as those which are not covered that they must still pay.

The deepest cut comes for those of the working poor who have signed up for care under the Affordable Care Act in the lower cost plan. I am among those. A broken rib when I was covered by the ACA resulted in $900 in medical bills I was not expecting (and in truth, I should have simply waited for my Medicare to kick on, but honesty or stupidity had me sign up for the ACA when I could no longer meet the asset test).

My experience is duplicated for many others. The reality for most is that these bills are never paid, so the providers eat the cost anyway. Making patients "responsible" has not helped providers one bit. They still eat much of the cost of treating "covered" patients.

The main danger to the Affordable Care Act is ease of entry and exit. If it is too easy to get in, then people will wait until they are sick to sign up. After they are well, any plan will stop coverage if you stop sending in your monthly premium check. If enough people do that, rates go up and the cycle goes down. This eventually leads to a collapse in the system that can be fixed in one of two ways – give everyone cheap and mandatory health care or place health insurers into bankruptcy, like General Motors and Chrysler, and reorganize them into a single-payer system (without any congressional action). Had the leadership laid out this scenario, it might have stopped the Affordable Care Act – and insurance companies would have most assuredly stopped contributions to the GOP.

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Committee on the Ways and Means

Pathways to Universal Health Coverage

Wednesday, June 12, at 10:00 a.m.

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